HOSPITAL BED AD HOC ADVISORY COMMITTEE

Wednesday, November 5, 2003

Conference Room A
General Office Building
7150 Harris Drive
Dimondale, Michigan 48821

APPROVED TRANSCRIPT-MINUTES

Ad Hoc Members Present:
James F. Ball, Chairperson
Robert Asmussen
Deborah Ebers
James B. Falahee
Terry V. Gerald
Larry Horwitz
John L. MacLeod
Sande MacLeod
Adam Miller
Cheryl Miller
Norah Maloney-Peash
Patrick O'Donovan
Dale L. Steiger
Don VeCasey (Arrived 12:00 noon)
Karen Yech

Michigan Department of Community Health Staff present:
Larry Horvath
William Hart
Stan Nash
Brenda Rogers

General Public Attendance:

There were approximately 31 people in attendance.

MR. BALL: For the benefit of the court reporter I would like to start with Adam and go around, indicate who you are, who you are representing. And this would be for the members of the ad hoc committee. Adam?

MR. MILLER: I'm Adam Miller. I am employed by the UAW, but I am here representing the AFL/CIO.

MS. MacLEOD: I'm Sande MacLeod. I work for United Food and Commercial Workers Local 951. I'm representing the Alliance for Health.

MR. HORWITZ: I'm Larry Horwitz. I work for the Economic Alliance for Michigan, and I am here representing them.

MS. MILLER: Cheryl Miller, Trinity Health.

MR. FALAHEE: James Falahee, Bronson Healthcare Group.

MR. MacLEOD: John MacLeod, Munson Healthcare.

MR. ASMUSSEN: Bob Asmussen, St. John Health.

MR. O' DONOVAN: Patrick O' Donovan, Beaumont.

MS. YECH: Karen Yech, Lakeland Regional Health System.

MR. BALL: I am Jim Ball. I am employed by General Motors and representing the Michigan Manufacturers Association.

MS. EBERS: I' m Deborah Ebers. I' m with the Greater Detroit Area Home Council.

MS. ROGERS: Brenda Rogers, Certificate of Needs section.

MR. NASH: I' m Stanley Nash, same place.

MR. MEEKER: I' m Bob Meeker from Spectrum Health, and I was on the Technical Advisory Committee.

MR. STEIGER: Dale Steiger, Blue Cross Blue Shield of Michigan.

MR. ZORN: Bob Zorn, MHA from the Technical Advisory Committee.

MR. BALL: Thank you. I note that the MacLeods are now gaining on the Millers.

MS. MacLEOD: Clan MacLeod.

MR. BALL: Clan MacLeod coming up close here. I think we have another committee member joining us. Two more members joining us. Terry Gerald and Norah Peash. The first order of business is to ask for any declarations, conflicts of interest. Does anyone have a conflict to declare? Seeing none, I will move on to review of the agenda. Does anyone have any suggested additions, deletions or corrections to the agenda? Seeing none, I will move on to review of the minutes of the February 21st, 2003, meeting. Do I have a motion to accept the agenda as printed, please?

(Motion made and seconded.)

Deborah Ebers made the motion, support by Sande MacLeod. All in favor say aye. Opposed? The agenda is adopted.

Review of minutes of February 21st, 2003. I believe the minutes were distributed in advance. Are there any additions, corrections or deletions to the minutes? Hearing none, I would entertain a motion to approve the minutes as distributed.

MR. FALAHEE: So moved by Falahee.

MS. MILLER: Second by Miller, Cheryl.

MR. BALL: Okay, approval of minutes have been moved and seconded. All in favor say aye. Opposed? The minutes are approved. We will move directly, then, to the report of the technical workgroup. Dale Steiger, Bob Zorn, Bob Meeker and their associates that worked on the workgroup will make the report.

For purposes of expediting activity today, I talked about this with Dale, and I think it would probably work best if they present the various sections of the report. Members of the committee who did not serve on the TAC and have questions, I would ask that we sort of retain the questions until the end of each section, address those questions, and then after the whole report is completed, then I will ask for public comment on the complete report. I think it may move faster in that way. Some of us may need to move so we can see the screen better, but if you gentlemen would like to proceed, you have the floor.

MR. STEIGER: Okay, thank you, Jim. What we would like to do today is go through the document that you have before you. You have every page that I think the department passed out earlier this morning.

The document as is sitting in front of you right now is not totally complete. We are going to need at least one more meeting of the Bed Need Ad Hoc Committee. What we have today are recommendations on the sub-area realignments and the changes or the methodology itself that was used to produce those sub-area realignments. We are going to talk about the bed need methodology itself and hopefully approve the changes that we have made to the methodology.

What we are lacking today are the bed need numbers themselves for the various sub-areas. The department is working furiously on that, I think. I hope. We could probably release Stan this morning to go back and work on the bed need numbers, but we need him this morning to answer all the technical questions. But the bottom line is we are going to need at least one more meeting to approve this whole thing.

And I think after going through it yesterday, through the document itself, I think as a technical group we are going to reserve the right to make some style changes, maybe make some different additional informational changes and add some information where we think it would help the document. But basically what you see this morning is the guts of the whole thing.

I'm going to go through this page by page. I'm not going to read everything. I think we will hit the high points. If the committee has questions, try to hold them for the end of the section. But the sections are kind of fuzzy, so we will try to entertain questions, if you have them, as we go along. I think that probably would be the easiest way so we don't get lost.

If you look at the membership of the group, we have a pretty wide representation from around the state. The committee that started out was quite a bit smaller than that. I think the CON Commission appointed somewhere in the neighborhood of five or six members of this group, but our philosophy was to open this up to anyone who wanted to participate. We welcomed all participation. We welcomed all expertise from anyone who wanted to participate.

So what you see before you are essentially all the names of folks who participated in one way or the other, some more than others. But it's a pretty large group and we were able to take advantage of everybody's expertise.

Jim mentioned before that we have a few other people, and he neglected to mention Stan, who is probably one of the most important members of the whole group, particularly for his historical perspective and his expertise in the whole subject.

Moving right along into the charge, we felt that we wanted to have the charge right at the beginning of the document so that people could see what we were about.

The technical advisory group is interpreting this charge language to be the following: Sub-area redefinition, which we'll talk about early on. Number two is the bed need methodology, and that is the methodology itself and the bed need numbers that are the output of the methodology. And the third item is the comparative review criteria.

We discovered some time ago that if there is a need in any of these sub-areas for additional beds, it's highly likely that there would be a comparative review situation develop, more than one applicant, and we discovered that there really are no comparative review criteria within the current bed need standards, so we have taken that on as an additional assignment. We are in the process of developing those criteria, and we will be coming back at the next meeting to review that. We will not talk about it today. Certainly in the meantime if folks have comments they want to make, they need to get ahold of a member of the Technical Advisory Committee or show up at a meeting and make those comments known to the group.

The next page deals with a little history. Talks about how HSAs were developed in the early seventies. I think the law was 93641. Goes back to my GDAHC days. We heard those numbers every day, certainly. So the HSAs go back to that. The HSAs themselves right now are caught up by several of the CON review standards. I think it' s referenced in state law, most recent revisions that will pass the CON Act.

The sub-areas themselves that are part of the HSAs, originally done in 1978 as part of the acute care bed need methodology project -- those of you who have been around for a few years remember that John Griffith and a bunch of other experts whose names escape me right now, I think Stan was probably one of the original group? No, not part of the original group -- developed sub-areas, developed the bed need methodology. And you can see down in the smaller blue bullets they' re what happened.

The original planning agencies, which I believe were the CHPCs around the state, we came to find out as we proceeded through the Technical Advisory Committee that Peg Reihmer, who is one of our members, played a pretty key role of developing these sub-areas way back when. We won' t talk about how old Peg is, but.

(UNIDENTIFIED SPEAKER): Thank you very much.

MR. MEEKER: She was in kindergarten when she did it.

MR. STEIGER: She can' t be any older than me, so it' s not a problem.

And Peg has assured us that when this process was first adopted a number of years ago that the process itself was a combination of the methodology, the numerical methodology which was based on population and discharge data, and expert judgment. And as we go through this today we will see the role that expert judgment has played in all this. We have attempted to use the technical expertise of people on the committee, but we have given things a sniff test at each step along the way to make sure that stuff made sense.

The next slide again talks about the history of the bed need methodology. The bullets that are laid out there are the original bed need methodology versus the revised one that we will talk about later on.

The second bullet there deals with the normative approach. It is important to remember that the normative approach was adoptive with the first bed need methodology because use rates in the state were so high back then that the experts, the health care experts that were gathered together to do this felt that there needed to be a way, one way, another way to drive down the use rates in the state. I think at the time they were well over 1,200 days per thousand. The goal of the original bed need methodology, by using the normative system, was basically to try and get that use rate down below a thousand days. And the thousand days was the original target.

We talked about target occupancy on this slide. I think you can see how it was originally laid out there. Pediatrics had a different occupancy. The adult target occupancy went up to 91 percent and average daily census was 200. As we go through this we will talk about the changes that were made on this.

The bed need methodology on page 7 talks about the revised bed need methodology that was rerun in 2001. At the time the methodology was run in 2001 was about the time that the Technical Advisory Committee was appointed, was originally appointed. So this group has been around a long time. Fortunately or unfortunately.

In 2001 when the bed need methodology was rerun, the numbers that we currently have in the standard, that was done with the normative approach. We obviously had not made our recommendations at that point, so that was the normative system that was used for the numbers that we currently have.

We did make a change, the Bed Need Ad Hoc Committee, this committee, did make a change before those numbers were rerun that we capped -- we changed the maximum target occupancy from 91 percent down to

85 percent to basically accommodate the changes that have been made in inpatient health care by developing smaller units, niche units, specialty units, that kind of thing.

The next slide is entitled approach. Basically this gets to the sub-area. This next section we are going to talk about sub-areas and how they were defined. The Technical Advisory Committee looked at at least two different methods for developing these sub-areas. We looked at Wennberg's "Geography of Health Care in Michigan." It was a publication that was originally sponsored or was sponsored by Blue Cross. And in that document Dr. Wennberg laid out health service areas, referral regions, those kind of things. And basically he used cardiovascular programs and neurosurgery programs as a way of developing regional referral centers for each of the areas in his state. And he ended up in that particular document with 15 hospital referral regions and about 109, I think, service sub-areas within the 15 hospital referral regions.

The Technical Advisory Committee looked at the current methodology, the Griffith methodology, if you will. John was good enough to come over one afternoon and spent four or five hours with the group and we went through his methodology. And the decision was made to basically update that methodology and to use that since we felt that was the best thing that is available in the country right now.

So for those Michigan State Spartans in the group, we give you something that came out of Michigan, but hopefully Cheryl, in particular, will forgive us.

MS. MILLER: I cleansed it. The cooties were removed.

MR. STEIGER: Okay, moving right along. Slide 8. At least these are numbered, aren't they Bob? So page 8, slide 8.

MR. MEEKER: 9.

MR. STEIGER: The major issues in the bed need methodology. We didn't in the beginning, but we had some issues we wanted to deal with, and one was the normative approach. The second one was the planning horizon, which we will talk about in a few minutes. And another issue was essentially how we handled adult beds versus on OB beds versus pediatrics. Do we want to aggregate those beds? How do we want to deal with those in terms of the bed need methodology itself? And we will get into that in a few minutes. The other major issue was the target occupancy. There were folks on the Technical Advisory Committee that felt that we needed to take a look at the target occupancy system so it would better reflect the way health care is currently delivered in this state.

The next slide again goes back to the normative approach. The problem, and it's not mentioned on this particular slide, but the problem that folks have on the committee, people felt that the use of the normative approach really did not truly reflect actual inpatient need, and particularly in lower income zip code areas. Lower income sub-areas. They felt that we really were shortchanging some of these sub-areas because the normative approach, again, dictated that the use rate in each individual sub-area end up being the statewide average or the actual use rate, whichever was lower. So if you had sub-areas that had an actual use rate that was higher than the statewide average, those sub-areas, the use rates that were used in those sub-areas basically were the statewide average.

So the argument a long time ago was that we had a lot of excess utilization, and one way to pull that excess utilization down was to put in a lower use rate in terms of the bed need numbers. We feel now that much of the excess utilization has been squeezed out by DRGs and managed care, and we wanted to develop a system that would better reflect the need of various areas around the state, the need for inpatient care and the need for inpatient beds.

So the decision was made as a proxy for something better. We looked at a number of different ways to get a proxy for income. Essentially we decided that there wasn't any easy way to do that. Really couldn't find any ways to do it, so we ended up using actual use rates. So the numbers that you will see at the next meeting, hopefully, will be based on actual use rates rather than normative system.

If you look at the next slide, it is a graph of inpatient use rates by household income compared to age, sex, adjusted statewide average use rates. So you can see with the blue columns, the lower the average income, and basically across the X axis we have income cohorts, these essentially are proxies for zip codes. Each one of these income cohorts corresponds to a specific sub-area. And you can see where the average household income is lower, the actual use rate is higher. And we felt that by using the actual use rates, this would be a good proxy for providing inpatient beds in areas that were really needed, based on lower income, lower people' s lower ability to get primary health care and those kind of things.

Bob, do you want to add anything to that? Since essentially we have Bob to thank for pulling this together. Bob did a lot of the technical work and kept people' s nose to the grindstone in terms of issues that he felt and MHA felt needed to be dealt with by this committee.

MR. ZORN: We felt the CON process calls for poor access as one of the issues -- is one of the missions of the CON Commission. And when you use the normative approach you understate the number of beds needed in poor areas because those people are using health care in greater numbers. For example, in the current bed need methodology, the average daily census for the Flint sub-area is something like 845, whereas the bed need is 843. And that is an approach, that is by and large using the normative approach, which again understated the need for beds in those areas.

So what we did is we -- Claritas gives us the medium household income of each zip code. We don' t have the individual income, but we have the medium household income of each zip code. We calculated the actual use rate for zip codes in each of the cohorts, and then we calculate the statewide use rates by age and sex, male 0 to 4 all the way up to 85 over, and applied those use rates to each of the cohorts to come up with an expected use rate. And so we felt this was strong evidence that a normative approach really disadvantaged those areas.

We also looked at it across the state and did it by county. Even in areas that typically have low use rates, Kalamazoo, Grand Rapids, the correlations held. The rates were different, but the correlations held. I don' t see a lot of people in the audience. Does everyone have a copy of this document as we are going through? Okay. Because I just noted you can' t see the titles in some cases.

Okay, the next slide deals with another issue we talked about and that was the planning horizon. And most folks felt that from a provider standpoint in terms of getting, recognizing need in sub-areas, recognizing need for additional beds, additional facilities, that really would almost be ten years before the need was recognized, going through the process, going through the ceiling process, getting the bricks and mortar up, that we would be looking at optimally a planning horizon of ten years. We will talk about that in a few minutes. That' s really not possible, but we will get into that in a few seconds.

The other question that we dealt with were OB and peed beds. Obviously these kinds of beds are not interchangeable with med/surg on a daily basis, so we felt we needed to deal with the bed need for OBs, peds and adults separately and aggregated those later on. We felt that was a big issue. We talked about that extensively, and essentially that' s listed there.

The target occupancy issue was a major concern for the group. (Unintelligible) to the nonproviders in the group showing with data that there is a lot of seasonality with hospitals, particularly in some of the rural areas where the seasonality depends on either the golf season or skiing season. But Bob made a good point that we need to be able to deal with that so when the need is out there we don' t shortchange the facilities. Day of the week, hour of the day, those kinds of issues. You can read the rest of it.

Other states' bed need methodologies. We felt obligated to take a look around the country to see what was out there and see if we had the best system for developing bed need. So we checked around the various sources. I think we ended up contacting probably eight or ten of the 50 states, the health planning departments in these 8 or 10 states. And essentially you can see what we discovered. There really isn' t anything in the country, essentially, that uses as sophisticated a methodology as we do here in Michigan.

We have always argued that the Michigan CON program is more sophisticated than just about anyplace else in the country. And I think we discovered when we talked to different people around the country, there really isn't anything out there that is nearly as good as what we have right now.

I talked to someone in Florida. And I got the woman on the phone and I indicated I wanted to talk to her because we had heard that they had a strong bed control program in Florida. And I think about three minutes later she quit laughing.

Essentially they do have a reasonable program in Florida. I don't have the history on it, but her comment was they don't use methodology, they just grill the devil out of people coming in. They have to get approval to have beds, but basically the applicants have to make a super strong case, and that's the methodology they use there.

You can look at Appendix C. We have a table laid out there that states what we dealt with and what folks found out.

Results and recommendations for the sub-areas. As I indicated before, we decided to use the Griffith methodology. Essentially, for those of you who have been around too long, you probably remember that all of this was originally run on the Michigan terminal system out of, I guess that was based out of the state universities, the computing systems in the state universities. All of that programming and all of that software went away. I don't know where it went, but it didn't exist. So we have a huge debt to Stan Nash, because Stan basically took the documentation -- we were able to find the programming written out in Fortran?

MR. NASH: PO One.

MR. STEIGER: Okay. Stan was able to find that, and basically we converted it into whatever he is using right now, which I don't care to get into. And if I explained it to you, you would see why. But we did have to reprogram the whole thing.

We looked at various outputs of the methodology. We looked at running the entire state as one HSA, if you will, and the results were under whelming. The state was just too big to do that. And we decided as we went along, and we ran, I don't remember how many iterations we ran or looked at, but we decided the best way to do this was to continue the HSAs and continue developing sub-areas for HSA.

I'm not going to get into the various alpha levels that were used or the mathematics that were used in the program, but I think suffice it to say that we ran all this any number of times. There were decision rules that are baked into the decisions that were made, and then we all looked at it to make sure that it made sense. And Peg Reihmer had done such a good job in some of the outstate areas that, as you will see in the next slide there, one of the slides, we really didn't make very many changes at all in the outstate areas.

Take a good look at slide 17, the application of the sub-area methodology. I'm not going to go through and read all of that. We did make some decisions as a group. And I want to make it clear that this was an incredibly objective group that we had. I won't say we were all very technical, but I think everyone was trying to do a very objective job. So we made certain decisions based on that objectivity, and as you see if you read through here and see each of the steps.

If the committee has any questions at this point, I'm going to throw it over to Stan.

But essentially the trick is to group hospitals based on relevance indices so that hospitals that deal with a particular population essentially are grouped together for planning purposes and for bed need purposes.

As a technical group we did talk about how we wanted to handle the output of these sub-areas. We felt that we wanted to have the same number of sub-areas or fewer of them. We felt there was really no need, there was no advantage to be gained by having more sub-areas. The problem is if you have more sub-areas,

particularly in outstate Michigan, you end up with a lot of single hospital sub-areas, and we felt that really didn't make a lot of sense for planning purposes.

The third bullet there, the DMC facilities, even though these facilities, I believe, were licensed as individual entities, we felt the best way to run the sub-areas for southeast Michigan was to consider the downtown DMC facility as one hospital. You can see what we decided with LTACs. That is sort of a no-brainer. The LTACS essentially are formed from beds in the host facility, the LTACS and the sub-area methodology assigned by definition as the same sub-area as the host hospitals.

And I'm not going to read or attempt to read the next to last bullet, but essentially these are small hospitals that really have not very good market shares in any areas. These were essentially hospitals that did not get reassigned or did not get assigned to a sub-area methodology, and so we did that manually based on that kind of a decision role.

We also felt as a technical group that because of the significant population in the three counties in HSA 1, Wayne, Oakland and Macomb, we felt it did not make any logical sense to have any single hospital sub-areas in those three counties. You will see there are single-hospital sub-areas in HSA 1, but not in the three counties that we dealt with here.

Essentially on slide 19 you could see in the top half of the slide the detail on what happened when the methodology was run and when the Technical Advisory Committee looked at it to see if it made sense.

And I believe that's two slides away, but we did make some decisions on three hospitals that border other states. You can read that. I'm not familiar with either Hillsdale or Sturgis. Certainly, Mercy Monroe in Monroe County is a significant hospital that serves a fairly significant area down there. Also those folks down there go to Ohio quite a bit. But those were the decisions that were made for those three.

And you can see, beginning on slide 21, might as well just jump to that, Bob, these are the maps of the hospital clusters. Remember, we are not dealing with geography with our sub-area definitions, we are dealing with clusters of hospitals that treat or deal with the same population. So just trying to be a pain in the neck last week I said, What if you live in Alcona County and you look at this, why aren't you included in any particular hospital cluster? And the answer obviously is we are not dealing with geography here, we are dealing with clusters of hospitals. And somebody that lives in Alcona County essentially would end up in Alpena or any other hospital of their choice.

We skipped over slide 20, but slide 20 indicates that the sub-area assignments listed by hospital are included as Appendix H. I believe, I am assuming that they were distributed by the department. Does everybody have those at this point?

MR. HORVATH: Actually, we are holding them back because we didn't want people to be confused. Gaye will go ahead and distribute them now. I noticed last night they are both titled Appendix A because that's the way they are titled in the standards. So just looking at the bottom of what Gaye passes out, one will say "by the TAC Committee," and the other will have an effective date.

MR. STEIGER: We took Appendix A out.

MR. HORVATH: And Larry put it back on. I put it back on by accident. I did. So Gaye will distribute it.

MR. STEIGER: For those of you who know all the hospitals in the state, you shouldn't need the list. But for those of you, like me, who don't, the list will detail each hospital and each sub-area it falls in within the HSAs.

MR. HORVATH: And in your packets the appendix are in back and they are properly titled with the label on them. Appendix A, Appendix I. So you will see two, one that is proposed and one that is current.

MR. STEIGER: And this, I think, is the U.P. I haven't been up there in a long time. I was up there once.

I' m from Pennsylvania. When I came to Michigan and somebody told me it was closer to drive back to New York City than it was to the other end of the state, I was kind of amazed.

That' s the U.P. The map is included in your document and the list will be coming around.

This is HSA 1. Again, in the three counties with the larger population, Macomb, Oakland and Wayne, there are no single-hospital sub-areas. The two, the three -- the single-hospital sub-areas, I think it is listed -- is that 11 or is that 1I? That' s probably 1I or 1L up there. River District Hospital on the St. Clair River. And the other one is down in Monroe, obviously.

MR. GERALD: A quick question. When you aggregate the DMC facilities on the main campus, what was the impact for doing that and what was the rationale?

MR. STEIGER: The rationale was that the outcome made a lot more logical sense. Stan, do you remember the specifics of running it individually?

MR. NASH: What I remember was that when they were disaggregated and run as individuals, what happened was that Henry Ford got grouped with Oakwood. And then the DMC downtown ended up separate, and that just didn' t seem to play ball. And after the combination of the hospitals, the four, I think it was the four hospitals, and it made them look like a single large hospital, which has a significant impact on the computations. All of that sub-area kind of came together in an expected way. And so what you see is what happened.

MR. GERALD: What they did is just combined them all into that single, into that one sub-area by doing that, otherwise we would have two sub-areas?

MR. STEIGER: No. The DMC Hospital would have been in one.

MR. GERALD: A single sub-area.

MR. STEIGER: Yeah. We really didn' t change them at all. Other questions?

Jim, I don' t know how you want to handle this, whether it is appropriate to move that we accept this sub-area at this point. As a bed need committee, not as a TAC. TAC has already done that. Or if you want to wait. I suspect giving public comment, we probably should wait.

MR. BALL: Yeah, I think that would be the preferred approach. Again, let members of the committee ask some questions, get the responses, work our way through it. Then go back through section by section and take public comment and have potential action by the committee.

MR. STEIGER: Any other questions or comments on the sub-area section?

MR. ASMUSSEN: As I looked at the current sub-area designations as compared to the four southeast Michigan, I noted three significant changes. The fact that Botsford and St. Mary Mercy are now comprised with a sub-area in themselves and the fact that Sinai-Grace moved from sub-area 69 into the city sub-area, could you explain how that occurred?

MR. STEIGER: I can' t explain specifically, but the general rule of thumb is that these hospitals that are clustered treat patients from those communities, and the relevance indices that apply in those sub-areas are because they treat patients in the same communities. And I will let either Bob or Stan get involved in the relevance indices part of it.

MR. ASMUSSEN: Then I guess the next question, and I only had one, would be then how would Botsford, since all the Oakland County hospitals are clustered except for Botsford, how is Botsford pulled out as distinct from any other hospital in Oakland County?

MR. STEIGER: Again the general answer is pattern of care. That's how the methodology is formulated. It aggregates hospitals that deal with the same patterns of care from the same communities. Is there anything specific that anyone remembers on that? Stan?

MR. NASH: And in general, the basic clusters were formed without any kind of manual manipulation by the committee members and were a function of the formula process itself. I mean, it's a little cryptic, okay, the methodology? but you need to know it was not manually manipulated in order to obtain a specified result.

After the basic clusters were identified, then a decision rule was made that the relevance indices for the cluster would then be calculated. And then for those hospitals that had not been included in those primary clusters, we would take their home zip code, in other words, the address of the zip code of their hospital, and look at the relevance indices for each sub-area, and the sub-area that had the greatest market penetration for that zip code, that's where that hospital got assigned. So in essence, that wasn't much of a manual process either.

The other thing that I think is very important to stress is that I think the committee spent at least a couple of hours looking at maps of this whole area that Bob had prepared with regards to market patterns. And we agreed that things are pretty complex down there, but by and large, there weren't - I don't think there were any arbitrary decisions as to how to group things.

MR. STEIGER: Stan brings up a good point about the maps. Because the committee essentially went through the methodology, applied the methodology, Stan applied the methodology, and when the sub-areas were clustered and the hospitals were clustered in the sub-areas, folks were just as curious as Bob. So I think Bob Zorn and Susan Bates from Spectrum put together a system of facts based on relevance indices for each sub-area that basically proved out the methodology. Any other questions or comments on sub-areas?

Okay, let's move into the bed need methodology. As I indicated earlier, we will talk about the methodology today and hopefully we can get the committee's approval and support on the changes that we have made, and we will have the numbers the next time we are together again.

We mentioned earlier on page 12 that (unintelligible) the optimum planning horizon is ten years. It is very difficult to do with the data we are using today because we have zip code population data only out to 5 years. Claritas can only project population trends at the zip code level, and the zip code level population is what we need for the methodology only out five years. So we essentially had to use that kind of a horizon.

The last bullet is age and sex cohort data must be available, data must be available due to significant variation. Obviously use rates and target occupancies for pediatrics and OB are different from adult med/surg, so obviously we need population data as part of that methodology.

The next slide deals with use rates. The current methodology, as is indicated there, uses four age cohorts. Folks felt that that really doesn't do justice to the way that need is calculated. That there are significant differences in the use rates between some of the age cohorts. So the decision was made, based on analysis that was done by a number of people, the decision was made to break the 15 to 64 age cohort into 15 to 44 and 45 to 64.

Can we jump ahead to page 28? You can see here on this particular slide the difference in the use rates between these various age cohorts. Particularly the difference between 45-64, 15 to 44. There are some fairly significant differences, particularly when you look at the statewide use rate, which I think they indicated in the document is around 600 days, but the graph shows 540.

MR. ZORN: It is a combination of both the difference in the use rate, and, in fact, we also have a big population bubble in the 45 to 64 age that uses different healthcare services that make it really apparent that those two things should split.

MR. STEIGER: And the last red bullet back on page 25 deals with the actual use rates versus normative use rates. I talked about that, the fact that we dealt with page 10. You could see the summary of what we dealt with there. And the decision, as I said, was made to use actual use rates as a proxy for need.

On page 26, a very important point here. Because adult beds are not interchangeable with OB and peds we are going to calculate the need for pediatric beds, obstetrical beds and adult beds separately and aggregate those numbers into one final number for each hospital for the sub-area -- not for the hospital, but aggregate those numbers at the sub-area level. So that we will have a sub-area bed need number for adults, sub-area bed need area for OB and the same thing for peds.

As the last bullet indicates, no measurable criteria were found to distinguish, and my thought last night when I was going through this is it is complicated enough without adding more.

Target occupancy. We spent a lot of time within the technical committee talking about target occupancy rates. As I said, the original methodology, going back to the Griffith years and the program and bureau years, it was felt that hospitals should be able to run at 91 percent. I know in some early years that I worked in hospitals we ran pretty consistently at 93, 94, 95 percent.

But I don't remember who in the technical group brought up a really excellent point. 20 years ago we used to run at very high occupancies, but when it really came crunch time, the length of stays were so long we were able to move people out a day or two early. Clean out the unit, if you will. Move people out of ICU and the surge. And we were able to get people in the beds when they were needed by cleaning other people out because the lengths of stay were, I won't say excessive, but out there a little bit.

Because the length of stay and use rates have dropped so significantly over the years, I don't know if Mark Mailloux made the point that we really don't have that kind of flexibility anymore, and, therefore, it is really pretty difficult to run a facility at 91 percent.

That got us into the discussion over what the target occupancy should be. Bob Zorn did a lot of work, analytical work with actual hospital data and has recommended the graph, the tables that are in here to get the target occupancies for sub-areas of a thousand back down to 85 percent, and it drops from there.

So the committee felt that these were pretty reasonable target occupancies for the adult side of it. We also have different targets for OB and different targets for pediatrics. You can see at the bottom of the slide they're what we ended up doing. We have looked at 28.

Okay, the committee, as we went through the bed need methodology we talked about a number of issues. One issue that came to light was the issue of critical access hospitals in rural areas and how those critical access hospitals impact the major, if you will, regional referral centers in the area. And I, quite frankly, wasn't very familiar with critical access hospitals, but I have learned that these are hospitals, very small. I think the federal statute indicates they can be a maximum of 15 beds, can have ten swing beds, need to be at least 35 miles from another hospital, and essentially the major purpose, I think, that they serve is that they are emergency rooms. They can put people in bed, they can hold them. If need be, those patients are transferred out of facilities.

But I feel a lot more comfortable, now that I have a piece of property in northern Michigan, knowing that I'm not too far from the critical hospital in Kalkaska. If I fall off the roof, someone will take me there, and eventually they will get me somewhere else.

But we spent a lot of time talking about how the numbers impact other hospitals in their sub-areas. And we decided that we did not want the bed need numbers and the hospital data to negatively impact bed need numbers that were produced in other sub-areas. So we have dropped, you can see we have dropped the beds out of the bed need calculation. We felt that this protects the regional hospitals in those sub-areas and it also protects, it allows the critical access hospitals to continue.

The third bullet, and maybe if somebody from the group could help me, I looked at this yesterday. Hospital utilization data should remain in the data base even after a hospital may close. We used 2001, and we will be using 2001 data for both the sub-areas and the bed need. I believe we have a few instances where the data is in the database because we don't want to lose that utilization data, but the actual hospital itself has closed since 2001. So we are going to leave the data, the recommendation is to leave the data in. I'm not exactly sure how long we decided to do that, but. Anybody want to jump in? Feel free.

MR. HORWITZ: Dale, isn't that the same- that's not a new recommendation. That's something that has been the case with the methodology all along. If, in fact, the people who are serving hospital A, B and C live in zip codes whatever --

MR. STEIGER: Right.

MR. HORWITZ: -- that's where you have to serve them. Even though the hospital three years ago they went to happens to have been closed, there is no responsible, legal way of reallocating it. It does mean in that sub-area where they are assigned it could be in some cases there is a bed need.

MR. STEIGER: Right.

MR. HORWITZ: And if someone, therefore, said, well, because that hospital closed, I'm going to apply for those additional, those beds, that would still be permissible. If you took the data out, you would be denying that sub-area the justification of need for those beds.

MR. MEEKER: It would only remain, since the recommendation already accepted by the CON Commission that the bed need methodology be rerun every two years, the maximum that that closed hospital data would be included in the methodology would be two years. So I think an example we have all used is Trinity Hospital in HSA 2, which in 2001 still had discharges, and so their data are in there. When it's rerun two years from now using 2003 data, those patients will already have gone to other hospitals and that sub-area will disappear.

MR. STEIGER: The last two bullets on 29, I believe the next to the last bullet needs a second asterisk. Both of those recommendations, I believe, were approved earlier in the (inaudible) commission meeting and are now incorporated into the standards.

As I indicated early on, the technical group felt that we needed to include as part of our charge the development of new comparative review criteria.

MR. BALL: Dale, excuse me. Are we shifting to another area where we should stop to see if there are any questions?

MR. STEIGER: Yes, actually, we are. I had assumed that there weren't any. I guess maybe that wasn't a good assumption.

MR. BALL: Are there any other questions on the bed need methodology section from any of the committee? Okay, go ahead. Sorry. Never mind.

MR. STEIGER: As I said, the technical group felt that in order to have a complete standard that can be applied by the department, that there needed to be comparative review criteria developed and incorporated into the hospital bed standard. These are the general categories that we have come up with so far in terms of comparative review criteria. We expect that we will be able to go over these criteria in detail at the next ad hoc committee meeting which is scheduled for November 13.

If folks feel that there are other major topics that need to be included in there, make sure you either come to the next technical meeting, which will be this afternoon, or that you pass your comments along to someone who is on the Technical Advisory Committee. Patrick?

MR. O' DONOVAN: Looking at these categories, the first two Medicaid participation and indigent care, what we are really looking at is provisions of care to populations for which you are not being provided for reimbursement costs. So I think as we look at that we want to consider unreimbursed care as unreimbursed care, so we are looking at Medicare as well. Just a comment I would like to make.

MR. STEIGER: Other comments? I' m not going to go through the summary. The summary is on page 31. That' s followed by the various appendices. Are there any other general or specific comments or questions by the ad hoc committee? Okay.

MR. BALL: Okay, well, if there aren' t, I guess what I would suggest is going back to the first section and seeing if we have any public comment in that area. This would be the issue of identification of the sub-areas. And if not, or after we consider the public comment we can then move to committee action on the ad hoc recommendations. Kyra Carter has submitted a card.

MS. CARTER: I' m with Sparrow Health System. I have been asked to read a letter from our CFO.

Thank you for this opportunity to come before the Bed Ad Hoc Committee to comment on the proposed changes to the hospital sub-area and bed need methodology.

Sparrow Hospital appreciates the Bed Ad Hoc Committee' s willingness to allow visitors to be present during the Technical Advisory Committee meetings. Sparrow did send representatives to these meetings from time to time, which allowed us to be informed about the proposed changes being discussed today.

In this matter the original charge given to the TAC under the direction of the Bed Ad Hoc Committee was to develop recommendations and/or resolutions to assist the ad hoc to complete its charge to correct and/or add revisions to the current bed need methodology to produce a standard that will allow an efficient update of Michigan' s acute bed care needs.

As a major medical center which has served mid-Michigan for over 100 years, we welcome and support further guidance in this area, as significant changes to healthcare have occurred since the 1970s when this methodology was originally developed.

However, we do have concerns with the current proposals as drafted by the TAC. These include: The proposed revision of sub-areas appears to be out of the scope and authority of the TAC. Based on the above charge, it would appear that the charge to review and update the methodology was meant to consist of updating the population statistics, use rates, and establishing current occupancy thresholds to account for changes in seasonality, staffing issues, specialized beds and not to redefine the patient migration subsections of the state. Thus, it is recommended that this proposed redefinition of sub-areas be found outside the scope of the TAC charge.

However, if the ad hoc committee concludes that the revision of patient migration subsections of the state is within the current charge, we would assert that the TAC should have started at the health service area level versus the sub-area level. The development of the HSAs was in the early 1970' s, and since this time health care has become regionalized throughout the state. The most rational approach to revision would be to utilize physician and hospital referral patterns which currently exist in Michigan and are documented by both the Dartmouth Atlas and the Blue Cross Blue Shield of Michigan Dartmouth Atlas. See the attached map. It would seem more appropriate to first update the HSAs before further subdivision takes place at the sub-area level. We would recommend the hospital bed ad hoc committee defer the proposed sub-area changes until such time a thorough and objective HSA analysis has been completed by the TAC, consistent with generally recognized methodologies like the Dartmouth Atlas.

With respect to the TAC' s overall processes to arrive at its overall proposed recommendations for changing the sub-areas, we are concerned that these procedures may not have the intended good, sound practice or reasoning usually required by the bed ad hoc committee or CON Commission. For example: It is not clear to us what rationale supports various alpha or market share thresholds which were chosen for each HSA.

This critical decision rule in the program is based on what value the TAC decided to assign as alpha, or the minimum market share, as opposed to some objective criteria. We note this is a critical aspect supporting the TAC' S recommendations and it has significant consequences to the end result. Note that if a large alpha factor is chosen, a small number of zip codes will be clustered together; and if a small alpha value is chosen, a larger number of zip codes will be clustered together. We are concerned that the alpha factor may have been chosen in certain HSAs to accomplish a desired end result versus having an objective methodology producing an objective end result.

It is not clear to us what rationale supports the various number of iterations the methodology was run for each HSA. It is possible that the number of iterations the methodology was run could influence the final outcome. The critical decision rule on the number of iterations should be based on some objective criteria and applied uniformly.

We also note a lack of formal minutes of the TAC deliberation process does not allow the ad hoc committee to track the discussions that led to the final decisions being proposed today. For example, because of the lack of formal minutes of the TAC, the ad hoc committee is not aware that certain participants voiced concerns with regards to the constant changing of selected alpha levels at TAC meetings, or that the representatives of the MHA, while participating in the technical aspects of the TAC, have no position on the proposed changes to the sub-areas being discussed today.

In summary, Sparrow does support the need for the update and revision of the bed need methodology as a current methodology is rooted in a healthcare industry of over 30 years ago. However, we do not support the revision of sub-areas as they are currently proposed today and would recommend that the Hospital Bed Ad Hoc Committee defer taking action on the proposed changes to the sub-areas until such time the overall HSAs are objectively reviewed in light of today' s regionalized approach to healthcare, and until such time objective criteria can be used to provide guidance on critical aspect of the methodology, such as the selection of the alpha level and the number of iterations the methodology is run.

Thank you for this opportunity to present our concerns and recommendations. If you have any questions regarding the above comments, please feel free to contact Jim Budzinski at 517, 364-5405. Sincerely A. James Budzinski.

MR. BALL: Thank you. Are there any questions of Ms. Carter? Thank you. I also have a card from Peg Reihmer from Botsford.

MS. REIHMER: Good afternoon. Maybe it is still morning, I' m not sure.

My name is Peg Reihmer, vice-president for planning at Botsford Hospital in Farmington Hills, Michigan.

And I' m going to make my comments very brief. I am here mostly as a member of the Technical Advisory Committee to ask that you approve the changes in the report as it is submitted by the workgroup. We did engage in a very lengthy and very rigorous process. Sometimes it was quite amazing to me how many hours it took to mull over a single issue.

I particularly wanted to address the question that Mr. Asmussen asked earlier, because as he received a very complete and technical answer from Stan with respect to the issue of Botsford and St. Mary' s being in a single sub-area, particularly the issue of Botsford in Oakland County Hospital not being grouped with the other Oakland County hospitals, there is a much simpler answer, which is that while Botsford is indeed in Oakland County, it is perhaps 100 yards into Oakland County and a much larger portion of our patients come from Wayne County and the city of Detroit than come from Oakland County. So that the grouping reflects the patterns of care for our particular organization.

I don' t have any other particular comments except again to urge you to adopthe report as submitted.

MR. BALL: Thank you. Any questions?

MR. ASMUSSEN: That' s a better answer than the first one.

MR. BALL: Any questions for Peg? Are there any other members of the audience who would like to make comment? If not, Terry?

MR. GERALD: Mr. Chairman, I appreciate all the efforts that the Technical Advisory Committee has put into this. And it is obviously a very technical area and will have significant implications. And since really this is the first time I have had an opportunity to see this all laid out in detail and discuss some of the impacts and implications, I, for one, am not prepared to vote on this at this meeting. Now someone made a comment that the ad hoc may be meeting again on November 13, and I don' t believe the CON commission is meeting again until December 9, so I think we do have some time. And I personally would appreciate the opportunity to, number one, be able to review this in more detail; and secondly, be able to discuss this with some of my colleagues prior to my taking a vote on the issue.

So my preference would be that we not take a vote today and that we schedule it again for the next Ad Hoc Advisory Committee meeting and take a vote at that time. But my preference would be not to take a vote on this at this time. Thank you.

MR. BALL: Are there other comments?

MR. ASMUSSEN: I would be interested in knowing the department' s position with regard to these recommendations. And I won' t just ask it that way, I will give a little background.It was my understanding that the department wanted the opportunity, after receiving these recommendations, to examine other methodologies and attempt to refine and improve this process, which is admittedly less than objective when you get down to deciding where hospitals fit. So with that as a little bit of background, I' m interested in knowing where the department stands at this point in time.

MR. HART: Bill Hart from the Department of Community Health. Jan can' t be with us this morning because he has some other things chasing and biting him. But the process that' s moving along, the department would like to have some additional opportunity to look at other options but does not want to stand in the way of the activity of this TAC and the ad hoc committee. So I suppose our position is neutral at this time, Bob. And the department, again, does not want to be a barrier to the continuing work of the committee.

MR. BALL: Any other comments? Larry?

MR. HORWITZ: I guess we have mentioned that this process has a long way to go yet. In other words, if the ad hoc adopts it today, it certainly is meeting again on November the 13th. I think it would be helpful to have at least a tentative judgment by the ad hoc so we could identify areas that seem to trouble people and areas that do not seem to trouble people, and then charge the TAC to come back with answers, explanations or justifications for whatever those are.

So, for example, the letter from Sparrow asks specific questions about why the number of the iterations and why the alphas and everything else, and to me it is only fair that they should get a response to that today, starting off with Stan and other members of the TAC. I certainly wouldn' t want to claim that I understood, am any expert on the alphas or how Stan kept us -- we ran the iteratons until they stopped. And I never did understand what caused the iterations to stop. Other than they pulled the plug or something.

But just in general terms of the process, it' s got to go to the- I suggest it would be helpful, because the methodology has not been updated completely in 30 years, when we did this three years ago it was on the basis that there were a lot of technical issues that needed to be addressed, and there would be a TAC to deal with all those things, the technical questions. And there have been various changes made in the methodology and the approaches since. This would at least give an opportunity to have something come forward. It would go to the CON Commission. It comes next to the TAC on November, whatever date you' ve got. We could conceivably have another meeting before December 9th if this committee so chose. December the 9th the only thing the commission would be doing is taking proposed action at most. They

might choose not to. Under the statute the ad hoc is the instrumentality of the commission and they clearly have been saying to this committee for some time that they want a report at the December meeting. No ifs, ands or buts.

Under the statute it's at the meeting of the commission that the department is to come in with any alternate recommendations, and the same with the office of the Attorney General, which the commission would then take into consideration. And which often has happened before is they maybe change it, maybe not, send it out for public comment. There would be no final action by the commission until a subsequent meeting of the commission.

So I think there is plenty of stages as we go through this process for checking out and simmering this through. It is a useful time today to identify what specific questions people have, where there seems to be areas of general comfort levels, where there seems to be problems, so those can be looked into.

In that regard I would hope that Stan could be asked to provide the courtesy of responding to Sparrow's questions about alphas and iterations.

In general, I think it would be awfully important, because we are an agent of the commission and they have been telling us for some time they want this process concluded, send it to them and they will take care of it, subsequently at which time there is plenty of opportunity for public comment, the department comment and everything else. The deputy director said once this comes forward, then the departments will look at it. The department can't even start coming back with its ultimate judgment and assessment until our work is done. So we need to get our work done so the department can then respond. At least that's my understanding. Is that correct, Bill?

MR. HART: I agree.

MR. HORWITZ: Okay. Thank you.

MR. BALL: And I agree also on the first issue that the Sparrow letter raised, the issue of the scope and authority of the TAC. There has been multiple discussions that have taken place, exchange of correspondence, and so forth, between myself, Dale, the department, the chair of the CON Commission, and I think it's abundantly clear that back when we updated the numbers, so to speak, that the need for updating the methodology was recognized. And the commission supported a continuing charge to this ad hoc committee and, B, the concept that we proposed of having a TAC advisory committee.

And there have been these issues of, you know, what is included at the last CON Commission meeting, for example. It was raised, I believe, by Jan or somebody from the department the issue of, you know, should the TAC or the bed need relate to the indigent care situation. And people at that time opined that indigent care didn't seem to have anything to do with need; need exists ortidoesn't. People need to be hospitalized or don't need to be hospitalized. But indeed there might be an appropriate place for that at the time need is established and then looking at comparative review. And perhaps that would be an appropriate place to deal with it. And so in addition to talking about exactly the bed need numbers and so forth, we get into recommendations on what they might do in terms of comparative review.

I fully anticipate that we will make what will be, hopefully, the final report from this ad hoc to the CON commission on December 9th. That they will accept whatever recommendations we have to put before them and they will discharge us with their thanks. And then they can carry forward to determine whether our recommendations should be adopted, whether some alternative recommendations should be adopted, or what it is that they want to do in light of the changes that have been made to the CON statute in light of the changes of the restructuring of how CON is handled and so forth.

I think we are probably the last existing ad hoc under the old statute. So we may be the last dinosaur here on the face of the earth.

So I guess I would respond to the first item raised in the Sparrow letter is that I think what we are doing is

within the scope of the TAC -- or excuse me, within the scope of the charge. And on those other questions I leave it to Dale and Stan and others to respond to those technical things. Whether they can do them today or indeed at our next meeting.

MR. ASMUSSEN: Sort of trying to connect the dots here from what Mr. Gerald said and other comments. We do have a meeting on the 13th and obviously the ability to finalize a position at that time.

I find, except for the argument over whether TAC had authority to deal with the sub-areas, just setting that aside, that that letter documents quite nicely many of the concerns of the recommendation, and it would be helpful to me as a member to have a written response to those points. And particularly since I understand that TAC is meeting this afternoon, an opportunity for them to reflect on those questions and get back to us would be most appreciated in my mind. I would feel much better in arriving at a judgment with that information.

MR. GERALD: I don't want to belabor the point, but the fact of the matter is this is a significant reworking of the methodology and this is the first time that we have really seen it in kind of written form and had a thorough explanation. And I appreciate that, Dale. But more importantly, it also is the first time that I think members of the public have seen it and have heard about it. And for those that are here and those who may not be here, I think giving us all at least a week to kind of mull this over, discuss it with some of our colleagues and others who will obviously be impacted by this in one way or another is a reasonable thing to do.

MR. BALL: Well, I guess I would ask what the pleasure of the committee is. We have had an opportunity to go through it, an opportunity for people to ask at least questions that they have had today, had an opportunity for public comment. I'm not sure that there is an apparent desire to have further inquiry or discussion today. If there is, let's have it. If not, if we are going to reserve it for a future meeting, let's make that decision. Bob Meeker.

MR. MEEKER: I would like to ask a question of the group as a member of the technical workgroup and reiterate some of the things that Larry said.

I appreciate all of the comments that have been made and I certainly think that most of them are very valid. As a member of the technical group I would like to know exactly -- in addition to the Sparrow letter, and there are one or two other questions that I have written down -- what do you want us to address between now and the next meeting? You know, I would hate for us to do a diligent job of trying to address your concerns and then come up with a whole new list of concerns at the next meeting.

Secondly, concerns about the bed need -- I'm sorry, the clustering, specifically I guess I should say, concerns about the hospital clusters has a tremendous impact on the running of the bed need methodology. In fact, I don't think I have heard any comments at all about the changes we have proposed to the bed need methodology itself, I think all of the comments have been on the clustering of hospitals. So assuming the methodology is okay, we can only apply that to identified clusters of hospitals. Stan has vowed that whatever he needs to do, he will have that for us next time. But if he runs it for one set of clusters and we say naw, naw, naw, we want a different set of clusters, then he will have -- I won't say wasted his time because some of them are going to stay the same, but a lot of them aren't. I think we need as much direction from this group as possible, as specific direction from this group as possible as to what you would like us to address between now and the next meeting.

MR. HORWITZ: I certainly don't have any concern about saying we wouldn't take definitive final action on all of this stuff. You have just seen it. It is eminently reasonable. But I do agree with Bob, we need to have some clarification of what there is.

So far the only issue that has been raised that I have heard of by anybody is the sub-area. And I want to make it clear that the sub-area reassignment is the subject of a mandatory standard requirement. We look at the current certificate of need standards which have the force of law. If you look on the page 3, there are copies in the back if people haven't picked it up, it says (inaudible) hospital sub-areas. These hospital

subsection 31 little i, A I. These hospital sub-areas, and the assignment of hospitals to sub-areas, shall be updated at the direction of the commission, and they have given us that direction, starting in May 2003, to be completed no later than November of 2003. That thereafter at the direction of the commission, updates shall occur no later than two years after the official date of the federal census. That means 2012.

So separate from the question of this charge, the commission is obligated to -- we are obligated to complete our work. The work of doing this is obligated to be completed in November. That' s what the standard says. So we need to be doing that. Above and beyond all the fine distinction between the bed methodology and sub-areas and comparative review criteria which are all linked in order to have a decision come out of the area of who gets any beds.

So I would very much agree with Mr. Meeker that I would ask that Stan and Bob Zorn and others who know more about alphas than I ever want to know, would respond to the questions from Sparrow, see if those are responsive and the judgment of the people here, see what other information needs to be brought forward so we don' t end up with a written document about the alphas and iterations and everything else and say, wait a minute, I have got three or four other questions. And then to see are there any questions about the methodology. Do people feel in general that the methodology looks okay to you? It seems reasonable to split up the age cohorts? A few years ago it used to be an age cohort of 65 and above and then we split it to make it 75 and above. Now we split, I suppose I would call the most of us, the 18 to 64 people, into two groups. We want to split it into five groups, 15 groups, whatever? And there is a lot of data here to justify that.

So what I would urge, Mr. Chairman, is that we start off with having Stan and Bob Zorn answer the questions that Sparrow has asked specifically about the sub-area process and the other questions that have been asked about the sub-area process and then determine are there any questions that anyone has about the methodology part of this. But we can' t generate numbers for you unless we have both.

So that would be my suggestion of how to proceed. And once we have that we can then adjourn and come back next week.

MR. BALL: Dale, Stan, Bob and Bob and Peg and whomever, can you respond to those today?

(Reporter requested a break.)

MR. BALL: We will take a five-minute break. I almost sense that we are going to be done before lunch, but we can take a five-minute break. Tell you what. I am advised that lunch is here and is being provided in the conference room. And per facility and cafeteria manager, food cannot be eaten in the cafeteria and must remain in the conference room. So why don' t we just break for lunch and I guess reconvene at 12:15.

(Lunch recess.)

MR. BALL: Okay, I will call the meeting back to order and turn the floor over to Stan. See what he can do here.

MR. NASH: And the first thing is that you need to know I didn' t have any opportunity to prepare a speech. So this gets off the top of my head, and I will try very hard not to ramble.

The first issue I want to speak to is with regards to the HSA designations. Very early on in the process the committee looked at the appropriateness of HSA boundaries as constraints for identification of hospital sub-areas. In addition, the department has also expressed concern with regards to the validity of those mostly political boundaries which were determined in the early seventies to be part of the hospital bed process.

Having said all of that, we were kind of brought back to reality by the fact that PA 619 has specifically identified HSAs as they currently exist as part of the constraints of that law. Well, we didn' t like it, but we kind of said we don' t have a whole lot of choice here.

Now, then, I will also tell you that even given that constraint, Dale pointed out to you that there were three specific situations where we chose to, I don't want to say violate, but let's say go against.

MR. MEEKER: Override.

MR. NASH: Override, good word. Override the HSA boundary. If you want to know who those were, one was Pipp, and it was moved from HSA 4 into 3, into the Borgess sub-area. And that's because we looked at the patterns of care, and guess what, that's where they came from.

A second one was Gratiot with what, Carson City? With Carson City, and that takes it out of 6 and puts it with 4, or the other way around, depending on your point of view. And again, when we looked at the market factors and the maps, it said those two belong together.

And the third one was Mackinaw Straits which got combined with Northern Michigan across the bridge because that's where the patterns of care go.

So even though the committee was not pleased with HSA boundaries, it felt it had no choice but to abide by those because that was dictated to them by PA 619. Even so, there are three exceptions where those rules were not followed.

Secondly, with regards to the methodology, when we tried to apply the methodology -- when I tried to apply the methodology to the whole state, I ended up with a mess. I mean, I ended up with hospitals trying to group with one side of the state to the other side of the state, and the results were so illogical that it was obvious that there was something very wrong. And when I went back to the TAC Committee, that's when the discussions about the HSAs occurred. And that determination was made.

Subsequently, and I'm going to try to really abbreviate this, and if I leave a hole and a question, you know, ask.

In the process of determining alphas and iterations, and I will talk more about those in a minute, what we found out was that there was a significant change in the way hospitals provide care today versus when that paper was written back in 1981, I believe.

Let me be specific. Back in 1980, or thereabouts, most hospitals, and the key word here is "most," hospitals provided about the same kind of care. You could go to about any hospital, with some exceptions, of course, and that's where the open heart and some of the real high tech stuff was, and get about the same level of care. But what became very obvious as we looked at the data was that that concept no longer remained. What indeed occurred was the concept of regional referral centers.

Let me be specific: Marquette. Marquette, without a doubt, Marquette General Hospital, is the regional referral center for the whole upper peninsula. And the rest of the hospitals up there are just - small. And inadequate. And many of the hospitals up there are the community access hospitals as well, which are 15 beds, you know, and you throw in the swing beds, are 25. So we are not talking about great big places. They are like if you have anything really wrong with you, you don't stay there very long. You go to a place that has the care that can be provided.

That's also true of Northern Michigan, of Munson, of the Grand Rapids Hospitals, Muskegon, Kalamazoo, Battle Creek, Lansing, Flint -- I'm sure I'm going to forget something here - Saginaw, and the Detroit area. And the Detroit area gets really complicated because you can't identify one or two major referral centers and say the rest go, everybody goes there. It's like there are several very large hospitals that do everything.

And then there is U of M who happens to be in a different county but in the same HSA that provides care to, I'd say, about 3/4 of the zip codes of the whole state. I mean, that's the extremes that we encountered.

Now, then, so one of the things that we clearly learned was that when the original model was developed, it

was developed for a model of care that we don't have. And of course you could say, Well, why didn't you just quit right there and throw it out? And the answer is because we believed there were some salvageable parts that we could make it work for us. And those decision rules to help make it work for us were in the presentation.

One of the major, one of the criteria is that there would be no more sub-areas than what currently exist in the HSA. It could be fewer, but there would be no more. That had a significant impact on the alpha level which was chosen to run the methodology.

Now, then, let me tell you briefly what the alpha level is. And this is very simple. (Laughter) Well, it is. It is. You have heard what market factors are, the relevance indices, the alpha level was merely the value at which you select relevance indices. I mean, so if you said I'm going to choose an alpha level of 10 percent, .10, that means that I am going to choose zip codes that have a market factor of .10 or less. The other way around, .10 or greater.

(UNIDENTIFIED SPEAKER): What's a market factor?

MR. NASH: Market share factor. And so based on the criteria that there should be no more than the existing sub-areas in an HSA, the alpha levels were chosen.

It should be noted that in the final result there are only two different alpha levels that were chosen across the whole analysis. One was .22, the other was .23. Which is not a whole lot different.

Now, then, in fairness you need to understand that that model is very sensitive to small changes in the alpha level. But still, to say that we used arbitrary alpha levels, no, that's not true. The alpha levels were chosen in order to control the number of sub-areas that were generated from the model within the HSA.

Now, then, let me tell you about iterations. In the paper --

MR. HORWITZ: Just one question. You are saying of the eight HSAs in the state, all of them either use .22 or .23?

MR. NASH: That is not true.

MR. HORWITZ: What did you just mean there?

MR. NASH: Let me clarify. That was a good question.

In our worst case example was the U.P., I'm sorry, the model didn't work there, period. It just didn't work. And for a specific example, where Schoolcraft Memorial is, Marquette General Hospital had a greater market share in Schoolcraft's home zip code than did Schoolcraft. And we would have ended up with one of two situations, one sub-area for the whole U.P., or each hospital in an individual sub-area. So what was done for the U.P. is what's there is fine. And that same philosophy was used for HSAs 4 and 6. So the methodology had nothing to do with --

MR. MEEKER: Not 6.

MR. NASH: Not 6, but 7. I'm sorry. So for three of the eight HSAs, the methodology has no part. And in the remaining, the remaining five, okay, I guess there was, I remember there were only two alpha levels. I do remember that. I guess there could be one with three, and the other -- there was at least two for each one. So it wasn't like we had one hanging out on a branch or something.

MR. HORWITZ: So the remaining five, were either with .22 or .23.

MR. NASH: Correct.

Now, then, for the iterations. Where there were a small, relatively small number of hospitals, the number of iterations -- let me stop right there.

I would run the model with a given alpha level, in almost every case, until the model reached stability. And by that I mean additional iterations would have not changed the clustering in any way. So you could have doubled the number, or whatever, and the outcome would have still been the same. I believe there was only one case where the number of iterations was terminated at a particular level to achieve the number of sub-areas that we ended up with. Because otherwise, it started grouping things and we ended up with much larger blops.

Now, then, let me give you a couple of examples. I think like for HSA 2 it was no more than about 30 or 40 iterations. And you can't quote me on that because I don't have the stuff in front of me. 30 or 40 iterations and the model was done. In the Detroit area it was 140 or 180. And that's partially a function of the number of hospitals that were in it.

Keep in mind that what would happen in all cases with an alpha level of .22 or .23, that which we chose, there would be some hospitals -- and this, of course, was true mostly in the southeast Michigan area, there would be some hospitals that none of the zip codes to which they provided service were at that level. So guess what happened to them? The methodology dropped them from the analysis. So what you ended up with on the output side was a list of hospitals that had been grouped, but that list was far shorter than the list that you, quote, "fed" into it. I think in southeast Michigan's situation there was 15 -- was it 15 or 17 hospitals? -- give or take a couple, that were dropped out because of that process.

So did we use an arbitrary number of iterations? No. No, we didn't. Did we use an arbitrary alpha? No, we didn't do that either. Now, we had some guidelines, which controlled what that alpha was, okay, but we didn't go in and manipulate it.

And the final process, like for the southeast Michigan where all of the hospitals -- I described that to you previously, where I took for a given sub-area, for the, quote, primary sub-area, which means the short list of hospitals, okay, I took those, took all of the zip codes that were represented by those hospitals, okay, formed a market factor and then allocated the hospitals that weren't in, based on market factors, in the home zip code of the dropped out hospital.

Let me give you an example of how extension -- you know, the computer is not lazy. For the sub-area that includes Ann Arbor, that included the aggregation of more than 800 zip codes. And the least number of zip codes that were utilized in southeast Michigan was about 300 or 400. So, I mean, we didn't just arbitrarily cut stuff off at the knees, we tried to include everything and make the model as responsive as possible.

Now let me give you a summary. Do I think the model is perfect? I already told you it's not. I think that it was developed at a time when the patterns of hospital care were very different. But I do believe that this committee worked together to try to overcome some of its limitations and used those and identified some rules by which basic parts of the methodology could still be used.

That's about the best I can do. Maybe I have muddled everybody up.

MR. BALL: Any questions? Larry Horwitz.

MR. HORWITZ: Stan, just for us nonplanners. Iteration, you keep going until it doesn't make any change. What are you doing in iteration X, then the X plus one, that is a different iteration? What is it that happens in each additional iteration until you stabilize?

MR. NASH: Okay, good question. Let me see if I can go to page 17. Okay. Let me tell you what happens. And this is, I mean, this is really the Readers Digest Condensed Version, But this is what happens. The market factor for every hospital for every zip code is calculated. Period. Okay, for each zip code we have the total population. Okay, now then, what we do is we multiply the market factor, and let's take the single

hospital here, We take the market factor for each zip code that that hospital serves, multiply it by the total population, and we add all those up. And once we add them up, we divide by the sum of the total population for those zip codes for which we used in the computation.

This will always give you a number less than one. By definition. And it is a single number. And in the paper it's called R-Bar. And then what's happened is you do that for every hospital. And then that list is sorted from low to high and you choose the hospital with the lowest R-bar value. It will then say this hospital is appropriate for potential clustering. And then what you do is you go through all of the zip codes that that hospital serves and you pick out the zip code that has the largest market share factor. And that's called that hospital's home zip code. Then you go through the whole rest of your database and pick out every other hospital that has provided care to that zip code. Among that list you choose the hospital that has the largest market share for that zip code. That hospital, then, is clustered with the one you first identified. And that's one iteration.

But now keep in mind I no longer have just single hospitals; I have a hospital and a cluster. So I have two hospitals in this one group. Now, I just repeat this. This is where the iterations come from. I repeat that whole process all over again. I find the one with the lowest R-Bar value, I find its home zip code, and I group it with the hospital or cluster in this case, because keep in mind that subsequent iterations I could group one cluster with another cluster. And that indeed does happen from time to time. And what happens is it just literally repeats itself until -- and I said we did this in all cases except one. We let it run until the number of clusters stabilized. In other words, no matter how many more times you ran it, you got the same number out of the back end.

We had one exception to that where I said. This is it. This is the number.

MR. HORWITZ: Why did you make that exception?

MR. NASH: Because letting it go further would have caused additional groupings. And the groupings --

MR. HORWITZ: So instead of reducing the number of groupings, it now began to increase them.

MR. NASH: No, it will never increase them. It's a gathering type of algorithm. So that there is always fewer and fewer groups. Once it reaches stability there are no additional groupings. But in this one case I stopped it before it did any more grouping. And I think it was in HSA 3, because of the proximity with Battle Creek with Kalamazoo. That what would have happened, the two would have joined.

So other than that, I hope that answers your question.

MR. ASMUSSEN: Stan, I thought the essence of the second question was the suggestion here that you first examine whether, in fact, the HSAs need adjusting before you worry about subdivisions thereof. And what you described, if I heard correctly, was simply the recommendation coming out of the TAC that with regard to three of them you moved hospitals.

MR. NASH: I believe my answer to that was there was no one on the committee who liked the HSA boundary designations, including the department, but we felt like we had no choice but to accept those because of PA 619. Because of its definitions of HSAs and the fact that it allows hospitals to move beds within an HSA if there is a joint ownership. And because of that we felt like we had no choice.

I mean, do I agree with you that the HSA boundaries are probably not super-appropriate? Yeah, I do. That wasn't the issue with us. The issue was we didn't think we had a choice.

MR. ASMUSSEN: You are saying you had no right to redefine the HSA boundaries? You've got no right to recommend adjustments in the HSA boundaries?

MR. NASH: We felt like we had no right to modify the HSA boundaries because it's in law.

MR. ASMUSSEN: As currently defined.

MR. NASH: As currently defined in law.

MR. ASMUSSEN: I have no idea.

MR. STEIGER: The modus operandi as we went along was not to worry about what if, but was to deal with what was in effect right now. So you could argue a what if, if you changed the law we could change the HSAs, but that' s not how we were operating.

MR. BALL: Mr. Meeker?

MR. MEEKER: Remember, we did start by running it for the whole state. And we ended up with the curious situation where Spectrum Health, Grand Rapids and Botsford Hospital were in the same sub-area. Along with about 50 other hospitals scattered in between. So that didn' t work.

So we needed to come up with some substate divisions just to subdivide the methodology. Not to cluster hospitals but just to say, you know, we can' t use the whole state and all the hospitals in it, we have to use substate regions, and we didn' t have any other basis for substate regions.

Now remember, we did look briefly at the Wennberg 18 different regional areas. We felt that that was just too many. That was too many subdivisions of the state before we even started the clustering process.

Stan' s right that in addition to thathe HSA boundaries are referenced in the law, and they are referenced in more than one place. They are also referenced in the section and deals with regional review agencies. Regional review agencies are authorized under the current law, and their boundaries are specifically identified to be HSA boundaries as defined back in 96.341.

Certainly as a planner it wouldn' t make sense to plan beds on a different configuration of the state than the HSA boundaries. Certainly you could use some HSA areas, but cutting it into eight different groups which have a history and which are referenced in a lot of other CON standards, I mean, this professional judgment seemed to make sense. It was the right number of subdivisions of the state without predetermining the sub-areas too much.

MR. BALL: Are there any other comments on the information Stan has provided? Questions?

Are there other issues that people want to raise for the ad hoc to consider -- excuse me, for the TAC to consider in its meeting later today? Karen?

MS. YECH: Looking at the subgroups, Lakeland has two of its three hospitals under a single Medicare provider number, but yet those two hospitals are in separate subgroups. Now, I don' t know how that will work out, but I think that needs to be --

MR. HORWITZ: What do you anticipate the implications of that?

MS YECH: Often patients are transferred from one hospital to another and are looked at from a Medicare billing perspective as just a unit to unit transfer, internal hospital transfer. And that would affect discharges also, then. You could be admitted in one hospital, discharged from another, and be filed with Medicare as a single admission.

MR. HORWITZ: What difference -- as you get paid by Medicare.

MS. YECH: Correct.

MR. HORWITZ: And they have an understanding of how to do that. The fact that the Certificate of Need

rules in Michigan say that hospital A is in a different sub-area than hospital B, how would that affect either the treatment of a patient or Medicare pay?

MS. YECH: I' m not sure. That' s why I have to go back and talk with our planner.

MR. MEEKER: Can I offer an opinion on that? It very well, because they are a single-license facility, they could be moving services between the facilities, just depending on what made sense from the operation of this single hospital, multi-location facility. And, you know, as they move services, that' s going to change patterns of care tremendously. It also might suggest that they would need to move beds, you know, either add or subtract from one facilities and go to another. As currently can happen within a sub-area.

And I have no particular vested interest in this. We have a multi-hospital facility, but it is all in the same community. But I would think that this is something that I think TAC should look at. I don' t know that there are any other situations like that in the state.

MR. STEIGER: I don' t believe she said it was a single license.

MR. MEEKER: Yes, she did.

MS. YECH: Single provider number.

MR. MEEKER: Single provider number. I' m sorry.

MS. YECH: Single provider number.

MR. STEIGER: For Medicare, not a state license.

MS. YECH: Yeah.

MR. HORWITZ: But right now if that did cause them to move beds from A to B, the law now allows them to do that. Because they are in the same HSA.

MS. YECH: They are in separate sub-areas.

MR. HORWITZ: They would now become different sub-areas, but they are now and would continue to be in the same HSA. And Public Act 619 says that if you have hospitals, that if you own hospitals within the HSA, you can move beds from any one of those hospitals to any other of those hospitals:.

MR. FALAHEE: One question for either Stan or Bob Meeker. In looking at the bubbles that are the sub-areas across the state, and listening to your comments, Stan, I understood at least half. Which is good. County lines don' t matter one whit, do they?

MR. NASH: No.

MR. FALAHEE: So what you are looking at is regardless of what county people live in, where do they drive to, drive to or get driven to get their
care.

MR. NASH: Yes, you are correct.

MR. FALAHEE: Thank you, sir.

MR. MEEKER: He' s right.

MR. BALL: You know, Karen raised an issue for the TAC to look at. And I don' t know what the separate licensure does, and Medicare may treat it as a single billing, but whether it still is a discharge and admission

to multiple hospitals or whatever, I think that's for the TAC to look at as opposed to debating it here. We are trying to find out are there more issues to add.

MR. STEIGER: Well, is there an issue? If there is an issue, I would like to have it specified specifically so we can deal with it. I'm not sure there is an issue at this point.

MS. YECH: I'm not sure how they handle it, but I'm pretty sure that when they discharge a patient, that may come out of a different subgroup area than the original admission hospital. So I'm not sure how they collect and submit the data.

MR. STEIGER: Whose?

MS. YECH: Lakeland. Between Lakeland Niles and Lakeland St. Joe.

MR. STEIGER: But I'm not sure what relevance it has on what we are talking about right now.

MS. YECH: Would that affect your market share data with your data you are using to define sub-areas? But it has to do with admissions and discharges.

MR. ZORN: I think one of the issues Karen is raising we need to look at. It is something which I hadn't been aware of until you just mentioned it. What happens, for example, if in the data we are getting if a patient is admitted to Lakeland, transferred to St. Joe. Now, under normal circumstances that's two admissions; admission, discharge, admission discharge. Under Medicare it would be an admission and a discharge, as if they moved from floor four to floor five. We need to double-check the data, because otherwise, what that would mean is -- you know if we are looking at patterns of care, there may be patterns of care we are not aware of because we are seeing a single discharge. We need to just double-check. I think it is valid to look at because it might be a data anomaly that we need to investigate a little bit.

MR. BALL: On the other hand, it would strike me, and I want to let the TAC deal with it, but it strikes me that, if anything, that would increase the amount of -- if anything, it would increase the amount of discharges, which would then perhaps overstate the need and is a bias toward overstating the need bed.

MR. ZORN: It would not overstate the need because we are dealing with days, not discharges, but would affect the sub-area assignment. Because the same patient would have overlapped, since that one patient is now at both hospitals. So it might affect the sub-area. It would not overstate or understate the need because we are dealing with days of the week, not discharges.

MR. BALL: Does anybody else have something that they would like to suggest for the TAC to look at? Larry?

MR. HORWITZ: I don't. It is just that I would like to get some reaction. So far all the comments I have heard is all about the sub-area assignment, including Karen's most recent one. Are there questions, commendations, objections, concerns about the methodology? The bed need methodology? The process by which we figure out how many beds are needed.

MR. BALL: I have not heard any today other than the comments made by Terry and, I think, Bob that this was the first opportunity that they had to look at it and have to reserve comments. But I haven't heard any criticisms of them. Are there any, Bob?

MR. ASMUSSEN: No. I would just comment, based on what I understood from this morning's presentation, that most of what I saw looked positive. But I'm the first one to admit I'm not an expert in the area. And if you allow, this eight-day period allows us to double-check that and ensure that, in fact, these are good moves. Certainly a cohort change seems to be a very positive one, at least among the ones I'm most familiar with.

MR. STEIGER: Mr. Chairman, to expedite this process I would like to urge this committee to urge the

department to go ahead and run the bed need methodology based on the sub-areas that were proposed this morning. The department cannot run bed need numbers and we can't fulfill our mission here, our objective, unless the sub-area, at least we have some sub-areas agreed upon. I don't know what the future of those particular sub-areas are, but at least in terms of running the bed need methodology sometime in November, I would like to urge this group to, perhaps without approving the sub-areas, but urge the department to go ahead and run the bed need methodology based on what we have seen today.

MR. BALL: I was planning -- thank you.

MR. STEIGER: That wasn't a motion.

MR. BALL: I understand. And I guess I have been planning on asking or instructing the department to do that in anticipation, again, of wanting to, assuming we are going to have another meeting and make some recommendations to the CON Commission and moving that forward to December 9. I think that from what I have observed, it seems like what's been done by the TAC is a great deal of hard work over an extended period of time and seems to be, as a nonplanning professional, seems to have been done on a very objective basis. And to me that is the role of the Certificate of Need, is to be objective rather than to say we have to create standards or methods to achieve a particular end. And I think the rationale employed by the TAC to arrive at the sub-areas they have, you know, shows a great deal of thought and a great deal of objectivity, and I think that the commission would be looking to say what is the outcome from this. And so I would ask the department to proceed on that.

Now, for the subsequent meeting, after people have had the opportunity to review, if somebody says, well, we think hospital A ought to be clustered in some other group and presents good rationale for that and that's adopted as a recommendation by the ad hoc to go to the commission, I don't think it would be critical for the commission to have the final numbers in the sense that we could say the department has run this based on this clustering of hospitals. Since that was directed, hospital A has moved to cluster nine and so that's going to tweak it a bit, but it would still permit the commission to say, yes, what's being done here makes sense and that potentially act on it. I don't think that they need to know or indeed want to know and base Certificate of Need decisions on this broad methodology on what happens to one particular hospital. So I would ask that the department go forward with that. Bob?

MR. MEEKER: Just to take that a little further. In the example you used, Jim, if, in fact, a hospital were to move from one cluster to another, it would not have any impact on the statewide bed need. It would just carve it up a little differently, and very little, unless it happens to be an enormous hospital, which is unlikely to happen.

So, you know, after Stan runs the bed need methodology, if you approve the approach to the bed need we have put forth, it will come up with a factor of beds needed for the whole state. And within rounding errors, that would be like three or four beds for the whole state. That will be the bed need for that methodology for the state for the planning year 2001.

MR. NASH: Six.

MR. MEEKER: I'm sorry, using the base year of 2001.

MR. BALL: Go ahead.

MR. STEIGER: I have slightly different issues.

MR. BALL: Well, let's hear your slightly different issue.

MR. STEIGER: Well, we have a meeting scheduled for next week. The TAC has indicated that it wants to review, just for a sniff test, the bed need numbers before they come to this group. And certainly, as I have said before, that committee is open to anyone who wants to attend.

I guess I have to ask the department what' s the likelihood ofhaving bed need numbers for next week. I' m assuming it is a very, very small probability. Then the question is do we want to scheduled another Bed Need Ad Hoc Committee for this month.

MR. NASH: Your assumption is correct. We are trying to work with the division of vital records epidemiology to provide the extra person support. Don' t know yet. I mean, we don' t have an answer back from them. Of course, I haven' t given it to them.

MR. STEIGER: What' s the question? Whether they are going to help?

MR. NASH: How long. How long it will take.

MR. HORVATH: The extra manpower has been committed. We are to get all the data sets over there. Stan is writing a couple things that that staff person is going to run for us. So the extra staff is committed. It is coordinating between the extra staff. We don' t know if it is going to be a week or two weeks to work out all the bugs. We will do our best to try to meet the 13th, the next ad hoc committee meeting.

MR. STEIGER: I think my point is Stan just indicated there is very little probability it could be done on the 13th, and certainly there is no likelihood of TAC getting together before that meeting. So I am suggesting that while we have everyone here, we may want to schedule another bed need committee meeting with some help from the department as to when that --

MR. HORWITZ: I' m not understanding. Are you saying that you think we have some chance of having bed need data by the 13th of November, Mr. Horvath?

MR. HORVATH: Stan?

MR. STEIGER: Say no.

MR. NASH: Slim. Slim.

MR. HORWITZ: Well, I suppose what I would like to suggest is that TAC also has to deal with this questions on the sub-areas. And you need to go deal with the work assigned on the comparative review items. We can still meet on November the 13th, and if perchance the data is there, so much the better

MR. STEIGER: I' m not suggesting we cancel the 13th, I' m suggesting we schedule another meeting.

MR. HORWITZ: Another meeting. I think that would make good sense. Since the commission meets on December the 9th, which is a Tuesday, do you think it' s a reasonable expectation that you could meet the week of, have the data by the week of the 17th?

MR. HORVATH: And you also have Thanksgiving in there.

MR. HORWITZ: No, I was deliberately picking the week before Thanksgiving. I' m thinking the week of the 17th is the week prior to Thanksgiving week.

MR. HORVATH: Can we give them -- I mean, is there a 50 percent chance? I mean, because we would hate to have you guys set the 17th and then --

MR. HORWITZ: Well, if we set it for the 19th of November, and the day before you tell us you don' t have it, if there is nothing else for us to do, the e-mails can go out to say we are not going to have a meeting.

MR. HORVATH: Brenda is reminding us the last time we checked with everybody the 17th was not a quorum, and that' s why the 17th was not picked.

MR. HORWITZ: No, I wasn't talking about the day of the 17th, I was talking about the week of the 17th. 17th, 18th, 19th, 20, 21. All the week prior to Thanksgiving.

MR. BALL: I guess I would question, assuming for the sake of argument that -- do people require to see the numbers to conclude whether they are ready to recommend to the commission the adoption of the methodology? Things like breaking the age cohorts and so forth? And the sub-areas and the standards for comparative review, do people need to see those end result numbers in order to make a decision on the recommendation?

I mean, it seems to me that our role is to say here is the formula that we are recommending you propose, and what numbers go into that formula and come out of it shouldn't change whether you think the formula is right or not. Again, my impression is we are trying to arrive at an objective methodology for determining need. And so, you know, while I think the commission is going to want those numbers and there seems to be a general interest in knowing them, is it critical to people saying, yes, I am prepared to recommend this methodology or these areas or whatever? Because if you can vote on the methodology and the areas and say other people can comment, then, to the commission, then you probably don't need this additional meeting, and it isn't critical for us to have numbers other than as a matter of curiosity. Now, you tell me.

MR. ASMUSSEN: Now, I think in response to your question, I think that if, in fact, this methodology was followed to the letter, or do what you suggest, but it has not been. Admittedly it has not been. So therefore, I think folks need to see the results before some, before they vote.

And to suggest that if there was opposition they could bring it to the commission, then it's one voice against a vote of the bed ad hoc and what chance does that voice have of truly being heard? So I think there is enough uncertainty about how the methodology was applied and all the exceptions that Stan talked about, the impact need to be seen before the people are assured.

MR. MEEKER: I believe that there is probably confusion. We, the technical group has dealt with two methodologies in a great deal of detail. I think, Mr. Asmussen, that you were referring to concerns about the sub-area methodology. I think what Mr. Ball is referring to was the bed need methodology. Certain planning year, certain cohorts of population, certain use rates. And so what I think he is asking is if we buy that planning methodology without seeing the result of it, then are those result, the actual bed need numbers, important? Clearly we need to do more work on the sub-area issue. And I don't think that's what you were asking.

MR. BALL: Yeah, I think so. But there seems to be this big need for yet another meeting, a compact time frame to do it, and I'm not sure that that's required. But again, I might be out in the ding wings here. Adam?

MR. MILLER: It seems to me that the test that this committee, this ad hoc committee needs to use to look at this methodology is, is it reasonable and was it designed by well-meaning professionals intending to present a reasonable application on a statewide basis. And I think that test has been met. I think it is procedurally fair. There are always going to be equity issues about individual institutions and individual situations, and I think the TAC, it sounds to me that they are willing to deal with those issues. And they have asked for specific issues already. But for purposes of this ad hoc, we are proposing, I think, a reasonable methodology, and I don't know if we can do any more. And to fly speck it to death is not going to help any of us. And I think it is time to close the door on this thing.

MR. GERALD: That may be the case, but it seems to me it might be worthwhile to go ahead and set a meeting on the week of the 17th and give the department the opportunity to try to get the data by then. And if they later in the week on the 17th, if they are not able to do it, then we can go ahead and make the decision without the data. But at least provide an opportunity for them to try to meet that deadline or that time frame. I don't see what harm there would be in doing that. If we can all get together the week of the 17th sometime.

MR. BALL: We have heard from the department there is a slim chance for the 13th. Is there any greater

chance for the week of the, you know, the following week? I suppose the other alternative is, to the extent you feel the numbers are critical, is to look at something in the first week of December. I mean, if that' s more realistic. But then you are bumping up against the commission meeting on the 9th.

MR. ZORN: I have one suggestion. I' m not urging the commission, obviously, to accept it, but it seems to me that maybe you might consider setting a meeting for the week of the 17th and not having the meeting of the week of the 13th. That would give more people time to get with concerns they might have and for us to be able to answer them before the next meeting. And then you might have the numbers on the week of the 17th and just have a single meeting.

MR. HORWITZ: I would like to support Bob' s suggestion. It increases the odds. We need time for the TAC to look at the other duties it has to present. Right? I suppose the key question is can we canvass the group here. We have everyone here on the TAC, on the advisory committee right now except one. Mr. Miller is the only absentee. Why don' t we canvass the group and see what we have attendance for the week of the 17th? I mean James Miller.

MS. ROGERS: Just as a reminder, when we initially polled a time to set up a couple of meetings for this group that week of the 17th, we checked and at that point in time that we checked, the 18th and 20th we had just a quorum on both of those days. So now maybe people' s schedules have just changed since then.

MR. HORWITZ: I am just suggesting we are all here, why don' t we have a hand indication of what we think.

MR. BALL: Can we assume that a facility would be obtainable?

MR. HORVATH: We have already rented the Holiday Inn for the 13th. We will just change it if needed. If we can' t find a state facility.

MR. BALL: By a show of hands, how many would be available on Monday the 17th? Tuesday the 18th? Wednesday the 19th? Thursday the 20th? And Friday the 21st? It looks like Tuesday the 18th has the greatest number.

MR. HORWITZ: How many was that?

MR. BALL: Raise your hands again for the availability on Tuesday the 18th. Thirteen.

MR. HORWITZ: Well, that' s 13 out of 16.

MR. BALL: That' s barely a quorum. By consensus, then, shall we move the meeting from the 13th to the 18th and hope to have the data available at that time? Are there any other comments from any committee members today or any comments from the audience? If not, I would entertain a motion to adjourn.

MS. MILLER: I just want to acknowledge the incredible amount of work that Stan Nash and Bob Zorn put in. They have done a great job and continue to do a good job, and I just want to emphasize the fact that they put in countless hours. A lot of us have, but they have really done the onus work.

MR. BALL: Is there a motion? Adam Miller moved to adjourn, seconded by Steiger. All in favor say aye. Opposed? Motion is carried. Meeting is adjourned.

Meeting concluded at 1:20 p.m.